

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027043

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 379
FILED JUN 24 1963

Primary Registration District No. 4553 Registrar's No. 14

STATE FILE NUMBER

VS 300
Rev. 4/59

1 1140

2 1140

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4 1

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9 331X

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12 90-0

13 3-1

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mansfield</u>		c. CITY OR TOWN <u>Mansfield</u>	
Length of stay in 1b <u>Lifetime</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>-----</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frona</u> Middle <u>Azalee</u> Last <u>Rippee</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		11. BIRTHPLACE (City and state or country) <u>Rural Mansfield, Mo.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert G. Rippee</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Ann Newton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mrs. Ora Riley</u>		Address <u>Mansfield, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 Hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS</u>		DUE TO (c) <u>-----</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>-----</u> a.m. <u>-----</u> p.m. <u>-----</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>-----</u> STATE <u>-----</u>	
21. I attended the deceased from <u>DEC 62</u> to <u>DEATH</u> and last saw <u>him</u> alive on <u>5/22/63</u>		Death occurred at <u>9:01</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Robert L. Sample M.D.</u>		22b. ADDRESS <u>Mansfield, Mo.</u>	
22c. DATE SIGNED <u>5/27/63</u>		22d. LOCATION (City, town, or county) <u>Mansfield, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 26, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mansfield</u>	
24. FUNERAL DIRECTOR <u>Max L Miller</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 17-63</u>	
ADDRESS <u>Mansfield, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>-----</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

JUN 24 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Mar L Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.